

What COVID-19 Can Teach Nurses About Liability Risks

How to protect yourself from unintended consequences when working during a public health crisis.

ABSTRACT: The COVID-19 pandemic has raised questions about professional liability risks for nurses tasked with caring for large numbers of severely ill patients while also challenged by resource shortages. This article will explore some key liability issues associated with the pandemic, including immunity, documentation, crisis standards of care, delegation and assignment, scope of practice, floating, travel nursing, telehealth, and misinformation and social media.

Keywords: COVID-19, liability, licensure, nurses, pandemic

For many nurses, the COVID-19 pandemic has raised questions about their potential liability risks in caring for increasing numbers of severely ill patients while also challenged by resource shortages. It remains too soon to determine how civil courts and regulatory bodies will respond to pandemic-related allegations against nurses. Because of the ongoing nature of the pandemic and the time it takes to resolve lawsuits, regulatory agency investigations, and disciplinary proceedings, COVID-19-related allegations will continue to work their way through courts and administrative proceedings for at least the next several years.

Without closed claims data available to analyze, it is difficult to identify with certainty the pandemic-related factors that may contribute to the most frequent or severe malpractice lawsuits or regulatory actions for nurses. Nevertheless, the start of the pandemic's third year presents an opportunity to reflect on the trends in nursing and health care that may affect nurses' liability. This can also be an opportunity to extrapolate what we've learned from this experience.

To that end, this article explores some key areas of potential liability associated with the pandemic: immunity, documentation, crisis standards of care, delegation and assignment, scope of practice, float-

ing, travel nursing, telehealth, and misinformation and social media.

IMMUNITY

To evaluate nurses' level of risk exposure, it is instructive to first review what, if any, liability protections are in place to help mitigate risk. Currently, various state and federal regulations, declarations, and orders offer health care workers some temporary immunity from COVID-19-related liability. At the federal level, these include the Public Readiness and Emergency Preparedness Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.^{1,2} Governors have also taken steps to extend immunity protections to health care professionals during the pandemic.³ However, while these temporary provisions provide some protection, they do not protect against claims of willful misconduct or gross negligence, nor do they protect an individual or entity from being named in a lawsuit.⁴

Plaintiff's counsel may file a medical malpractice lawsuit if counsel believes its client was injured as the direct result of a nurse's professional services, including a failure to do what a reasonable nurse would have done under the same or similar circumstances. In the best-case scenario, a judge will determine that immunity applies to the nurse, and the

nurse will be dismissed from the lawsuit.⁴ Yet, even in those cases, mounting a legal defense in order to be dismissed from a lawsuit necessitates hiring a defense attorney, which incurs significant expense.⁴ Moreover, regulations differ by state, and immunity provisions do not protect nurses from state regulatory board investigations and discipline, including state board of nursing (SBON) actions.⁵ Therefore, irrespective of the limited protections that immunity provisions may offer, nurses should take steps to protect themselves from medical malpractice lawsuits and SBON investigations, such as those outlined in this article. As they say, forewarned is forearmed.

DOCUMENTATION

Creating and maintaining complete and accurate health care records has always been an essential risk management measure. In times of resource shortages or crisis, this documentation becomes even more critical, yet the time needed to complete it may be limited.

Nonetheless, regardless of situation or time constraints, nurses are accountable for their documentation, and a patient's health care record is expected to accurately reflect the patient's condition and interventions at the time of care. This record is key to communicating clinical information to other members of a patient's health care team and to advocating for the patient's well-being and safety.

Notably, deficient documentation compromises the defense against many professional liability claims, as well as to SBON complaints against nurses.⁶ Moreover, nurses must comply with their employer's policies and procedures regarding the information that must be included in the patient record, especially during crises. During severe staffing shortages and other exigent circumstances, employers may alter documentation expectations, for example, by employing strategies such as charting by exception, only documenting high-priority care and abnormal assessment findings, or entering a standard note within the electronic health record to indicate that patient care was delivered during a crisis.⁷

Employers should work with nursing staff to develop short forms designed to facilitate the documentation of critical information. If nurses are uncertain as to employer expectations for documentation during crises, they should discuss the issue with their supervisor or administrator and ask for a written charting policy.

CRISIS STANDARDS OF CARE

When resource shortages necessitate a change in the level of care delivered, hospitals may activate crisis standards of care protocols.⁸ These reflect a change in a hospital's ethical framework from "patient-



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centered" practice to "public-focused" practice.⁹ Ethical frameworks are analytical guides designed to help health care providers draw on professional, ethical values to make clinical decisions in situations that are morally complex.^{8,10} During a public health emergency when resources are scarce, nurses must balance their duty to provide patient-centered care with considerations for the good of the public.⁹ Throughout the COVID-19 pandemic, for example, when there were national shortages of personal protective equipment (PPE) such as surgical masks and N95 respirators, many nurses were asked to conserve and reuse single-use PPE.¹¹

However, the American Nurses Association (ANA) advises that "no crisis changes the professional standards of practice, Code of Ethics, accountability for clinical competence or values of the registered nurse."¹¹ Even in times of crisis, nurses will continue to have informed consent, patient safety, and end-of-life care discussions with patients and their families. Public health emergencies may also require nurses to take on additional responsibility as "enforcers" of evolving guidelines and policies because of their inherently close relationship with patients and their families. During the COVID-19 pandemic, for example, nurses often had to enforce their facilities' infection control and visitation policies with patients and their families. These situations required nurses to apply these policies fairly and equally.¹²

To provide optimal patient care in less-than-ideal circumstances, and to help protect themselves from potential liability, nurses should maintain open lines of communication with other members of the patient health care team and their supervisors. Crisis standards

Case Study 1: Emergency Ondansetron

An RN working on the postanesthesia care unit was caring for a patient who was experiencing extreme nausea. The nurse made several unsuccessful attempts to contact the treating provider to get an order for ondansetron (Zofran). The nurse called the pharmacy and relayed her concern for the patient's nausea as well as her inability to reach the patient's provider. The nurse informed the pharmacist that she believed the patient's condition was urgent and that she would contact the provider for an order.

The pharmacy dispensed ondansetron and the nurse administered the medication to the patient. Although the patient did not suffer adverse effects from the ondansetron, no order was ever received for the antiemetic medication. Moreover, the nurse did not attempt to contact any other provider prior to ordering and administering the medication.

Upon finding that the nurse violated the nurse practice act by practicing beyond the scope of practice for an RN, the state board of nursing publicly reprimanded her and ordered her to pay a fine of \$600.

Case studies 1 and 2 are adapted with permission from the Nurses Service Organization and CNA. *Nurse professional liability exposure claim report: 4th edition*. Fort Washington, PA; Chicago, IL: Affinity Insurance Services; CNA; 2020 Jun.

of care shift frequently in response to changing conditions and availability of resources. But any such shift must be implemented in accordance with employer policies and procedures, and in collaboration with other health care providers.¹¹ Therefore, nurses should ensure they are following the most current standards by remaining in close communication with their manager, monitoring state or local announcements, and frequently consulting their SBON website for updates.

When resources are scarce to nonexistent, it may be difficult to balance the demands of an ongoing public health emergency with those of individual patients. But while crisis standards of care offer some temporary protections for health care providers to allocate scarce resources, nurses should remain aware that the ANA's *Code of Ethics for Nurses with Interpretive Statements* "obligates professional nurses to respect the dignity of every person in their care while also upholding the public good and collective human rights."^{11, 13}

In addition, nurses should be mindful of their perceptions (and misperceptions), and of how implicit bias can affect their assessment of the quality of life or relative "worth" of patients and their decision-making regarding resource allocation.^{14, 15} On top of other nursing responsibilities, equity demands exerting an extra effort to properly care for patients from historically marginalized communities.¹⁶ This extra effort should include endeavoring to understand the impact that historical and current inequities have on patients' health and well-being. For example, many of the conditions that increased patients' risk of severe

COVID-19, including hypertension and diabetes, tend to be more common among Black and poor patients.¹⁶ Failing to account for how race and other social factors influence patients' health during resource allocation can further disadvantage marginalized patients.¹⁶

DELEGATION AND ASSIGNMENT

When nursing resources are limited or scarce, nurses may be required to delegate, assign, or hand off certain nursing tasks or responsibilities to nursing students, recently retired nurses, other licensed health care workers, temporary staff, and unlicensed assistive personnel (UAP). To meet the needs of patient surges during the COVID-19 pandemic, for instance, many hospitals implemented team-based staffing concepts to accommodate nurse staffing needs.¹⁷ This often resulted in the redeployment of support staff or non-ICU or critical care nurses to support ICU-level or critical care-level nursing care.¹⁷ These situations raised concerns about the ICU or critical care nurses' responsibility for the nursing care they handed off to others.

When working with emergency workers or support staff during crises, it's important to understand the distinction between a handoff and the delegation or assignment of nursing tasks. While their definitions may differ depending on the state or jurisdiction, *delegation* and *assignment* allow a licensed nurse, such as an advanced practice RN, RN, or in some cases LPN/LVN, to transfer a nursing task to an RN, LPN/LVN, or UAP. In the case of both delegation and assignment, the licensed nurse transfers an activity, skill, or procedure but retains responsibility for the patient.¹⁸ In a handoff, by contrast, the licensed nurse transfers the responsibility for a patient's care to another licensed provider, as when an RN hands off to another RN at the end of a shift.¹⁹

The National Council of State Boards of Nursing (NCSBN) describes an assignment as involving "the routine care, activities, and procedures that are within the authorized scope of practice of the RN or [LPN/LVN] or part of the routine functions of the UAP," whereas delegation is described as "allowing a delegatee to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed."¹⁹

While a nurse's employer and nursing manager are responsible for developing, overseeing, and communicating information about policies and procedures related to delegation, assignment, and handoffs, delegation and assignment of tasks are ultimately within a licensed nurse's discretionary authority.¹⁹ Licensed nurses are responsible for determining when and what tasks to delegate or assign, depending on the situation.

When it comes to delegation, there are several patient safety and professional liability considerations for nurses. First, nurses should know their

employer's policies and procedures related to delegation, their state laws and regulations pertaining to delegation, and the scope of practice for their nursing license and the delegatee's license or certification, as defined by the SBON. As elsewhere, ignorance of the law is not an excuse. Unfamiliarity with current policies, procedures, regulations, or scope of practice is not a valid defense in the event of a civil lawsuit or SBON investigation.

The delegating nurse should also be aware of the delegatee's knowledge and skills, training, diversity awareness, and level of comfort with the tasks.¹⁸ The nurse also needs to exercise sound clinical judgment in determining the tasks to delegate—and should be ready and able to monitor the implementation of any delegated task.¹⁸

If unsure whether it is appropriate to delegate an activity, the nurse should not delegate but should perform the activity instead. Once having delegated, however, the nurse should be prepared to step in and take over the delegated task(s), as appropriate, and provide the delegatee feedback for improvement.

SCOPE OF PRACTICE

When resources and staffing are limited, it's important to balance providing safe, expeditious patient care with the risks of taking actions outside one's scope of practice. For example, RNs can face disciplinary action by SBONs for skirting the professional standards set forth in their state's nurse practice act concerning a patient's diagnosis, making changes to patients' prescribed treatment, or administering medication that hasn't been prescribed.⁶

For two case studies that illustrate the consequences for nurses accused of providing health care services beyond their scope of practice, see *Case Study 1: Emergency Ondansetron* and *Case Study 2: Whose Order?*

Regardless of the intentions of the nurses in those two scenarios, RNs should never treat a patient without provider orders, standing orders, or orders based on unit protocols. Nurses should also be aware of the limitations of the nurse practice act(s) in the state(s) where they practice, as each nurse practice act is different. Because nurse practice acts are intended to offer only general guidance, nurses should make sure they are familiar with their employer's protocols and policies that delineate their roles and responsibilities.²⁰ During crisis staffing situations, when nurses may receive only a few days' orientation before being deployed to a staff nursing assignment, such knowledge is critical. In these situations, nurses are responsible for familiarizing themselves with the state's nurse practice act, as well as all relevant facility policies and procedures.

FLOATING

Health care facilities often address staffing shortages and patient surges by floating nurses to units

where they don't typically work. Ideally, the new unit should be similar to the nurse's usual unit. On occasion, however, nurses may be assigned to work in unfamiliar areas. While a patient assignment may fall within a nurse's scope of practice, it may not be completely within their realm of training or experience.

These situations can present a difficult choice for nurses. Refusing to accept the assignment could lead to accusations of unprofessional conduct or insubordination, discipline, or even dismissal.²¹ Nevertheless, if the nurse is not equipped for the assignment, patient safety may be compromised.²² There are several risk management considerations nurses should keep in mind if they are asked to float to a new unit.

First, nurses should alert their supervisor if they have limited experience in a particular area and don't believe they can safely accept responsibility for the patient assignment, describing the specific tasks for which they do not feel equipped.²¹ The supervisor may decide to offer the assignment to another nurse or may work with the first nurse to ensure preparation for the assignment.

However, if an assignment is within the nurse's scope of practice, there may be little recourse for refusing it. Nurses may consider submitting an "assignment despite objection" or "assignment under protest" form after accepting an assignment that concerns them. These forms permit nurses to explain their concerns about the potential for unsafe conditions for patients and staff while fulfilling their obligation to their patients. They can also be useful in defending the nurse in the case of an adverse event. After completing such a form, the nurse should provide copies to their supervisor or administrator and keep a copy for their records. If similar problems with assignments continue, the nurse should raise the issue through the chain of command.

Ideally, nurses will receive a comprehensive orientation before working on any unit, but this may not be the case for floating nurses because of resource constraints.²³ In lieu of a full orientation, floating nurses should ensure they receive a basic orientation that includes a review of shift routines; key equipment

Case Study 2: Whose Order?

An RN made changes to a patient's ventilator without a physician's order. The nurse then requested that a resident physician submit an order for the changes that the nurse had already made. The nurse did not believe that first-year resident physicians could give an order for patients on the critical care unit, so he falsified the records by documenting that the orders had come from a different physician. When asked about the incident, the RN lied, stating that it was an unintentional error. The state board of nursing suspended the nurse's license for two years.

locations; contact numbers; patient care expectations; documentation that is specifically required on the unit; and written copies of the unit's policies, procedures, and clinical practices.²²

Floating nurses should also be assigned to a more experienced nurse who can help them navigate questions or concerns.²³ By advocating for themselves and for patient safety in these situations, nurses can help ensure that patient care does not suffer.

TRAVEL NURSING

As rates of COVID-19 infections have ebbed and flowed across the country, many health care facilities have increasingly relied on travel nurses.²⁴ For example, during the first surge of infections in April 2020, demand for travel ICU nurses increased from January 2020 by 612% in Massachusetts and 1,038% in New York State.²⁴

Working in unfamiliar environments and in multiple jurisdictions have potential liability implications, but travel nurses can practice proactive risk management strategies to help protect themselves and their career. Before accepting a travel assignment, nurses must ensure that their license will permit them

to practice in that state. Multistate licenses are available for nurses who live in states that have enacted the Nurse Licensure Compact.²⁵ Temporary licenses may also provide an option for nurses awaiting a permanent license. During COVID-19, some statutes and regulations regarding licensure portability were temporarily relaxed or waived. Nurses should consult the SBON(s) where they will be practicing about licensure requirements, which may differ during and following the emergency period.

On occasion, travel nurses, like floating nurses, may be given patient assignments outside of their typical practice areas and locations. They, too, should advocate for themselves and for patient safety by speaking up if an assignment exceeds their skill set, level of competency, and/or scope of practice. For a situation in which a travel nurse attempted to advocate for herself but went about it in an inappropriate way, see *Case Study 3: Assignment Refused*.

Travel nurses should reach out to their supervisor with questions or concerns if they object to an assignment, but this case study points to several key issues. Although the RN in the case study took appropriate action when she advised her supervisor that she had not been cross-trained in the ED, there is little recourse for nurses who refuse an assignment that is within their scope of practice. This is especially true when the supervisor attempts to offer the nurse an acceptable accommodation. This RN could have submitted an “assignment despite objection” or “assignment under protest” form following acceptance of the assignment, which would have permitted her to fulfill her obligation to her patient and also formally document her concerns.

This case study also underscores the risks associated with multistate licensure. While a multistate nursing license allows nurses to practice in more than one state, it also means that the nurse's practice falls within the jurisdiction of multiple SBONs.²⁶ Each SBON is authorized to investigate a licensee's conduct and take disciplinary action based on the action taken by another jurisdiction.²⁶ Consequently, as we see here, one instance of professional misconduct or violation of a state nurse practice act may lead to reciprocal disciplinary action by other states, the purpose of which is to “prevent the nurse from evading disciplinary action merely by fleeing the state.”²⁶

Therefore, it is advisable for nurses to limit the number of states or territories where they hold active nursing licenses to only what is necessary for their current role and nursing duties. And, again, before accepting any travel nursing assignment, nurses must understand the state's nurse practice act and any state-specific adverse event reporting system, review the SBON website for practice information, and follow the facility's policies and procedures.

Case Study 3: Assignment Refused

One day, an RN who had been working as a travel nurse in an ICU was assigned to take care of an ICU patient who was placed on hold in the ED while waiting for an ICU bed. The RN expressed concern to her supervisor that she had not received ED cross-training from the hospital. She said she didn't want to float to an unfamiliar unit without being cross-trained, as was the practice of every other hospital she had worked in.

The RN's supervisor responded that the assignment consisted solely of this one patient and that she would have no responsibility for any ED patients. The supervisor further explained that the medications for the patient would be provided to the RN in the ED and that the nursing interventions and level of care were the same as those an ICU RN would provide. The supervisor offered to take the RN to the ED and introduce her to the ED shift coordinator to confirm her single ICU patient assignment.

The RN refused to accept the assignment and left the hospital without approval from her supervisor.

The hospital terminated the RN's contract and filed a complaint against her with the state board of nursing (SBON). SBON investigators found that the RN had failed to provide an acceptable reason for leaving the hospital without approval and before a replacement could be found. The SBON concluded that the RN's conduct constituted an act of professional misconduct, issued a public reprimand against her license, and reported the adverse action to the National Practitioner Data Bank and the Nursys database.

As required, the RN reported her actions to the two other states where she held active nursing licenses. Each of their SBONs subsequently initiated their own administrative proceedings, with one ultimately issuing another public reprimand and the other levying a fine against the RN.

TELEHEALTH

Telehealth and telemedicine involve “the use of electronic information and telecommunications technologies to extend care.”²⁷ At the beginning of the COVID-19 public health emergency, the U.S. Department of Health and Human Services and many states issued temporary measures and guidance to make it easier for health care providers to serve patients through telehealth and seek reimbursement for their services.²⁸ These measures contributed to an increase in telemedicine visits.²⁹ For example, according to a cross-sectional analysis of the U.S. National Disease and Therapeutic Index audit of more than 125.8 million primary care visits between 2018 and the second quarter of 2020, telehealth visits rose from 1.2% of all primary care visits in the second quarter of 2019 to 35.3% in the second quarter of 2020.²⁹

Although many patients have since become comfortable with telehealth visits—and indeed, may prefer them—the future of telehealth remains uncertain, as some of the temporary policies and waivers imposed during the pandemic have expired, and more will expire at the end of the emergency period without federal or state intervention.³⁰⁻³² During this time of great change, nurses must be cognizant of potential liability exposures associated with telehealth practice.

According to the NCSBN, nursing practice, whether in person or via telehealth, “takes place in the state where the [patient] is located at the time nursing service is provided.”³³ Additionally, some states require telehealth providers to be licensed in the state where the patient is located. Therefore, before participating in any telehealth treatment or services, nurses should ensure they are appropriately licensed and/or credentialed to provide telehealth services, and that their work falls within the scope of practice for their license in the relevant state(s).³⁴ These requirements also mean that nursing via telehealth has risks regarding practicing in multiple jurisdictions, similar to those of travel nursing.

Nurses providing telehealth services must adhere to the practice standards they follow when providing traditional in-person treatment and care. For instance, patient consent is always required prior to initiating telehealth services, as is a discussion of the potential benefits, constraints, and risks unique to telehealth services, as well as potential alternatives.²⁷

And finally—because in every crisis there can be acute mini-crises: nurses should also be aware of their employer’s emergency or contingency plans in the event of a technology breakdown.

MISINFORMATION AND SOCIAL MEDIA

Social media can be a double-edged sword. On the one hand, we’ve never had easier access to information from all corners of the world. On the other hand, appeals to emotion and personal beliefs tend

to become more influential than objective facts.^{35,36} Thus, relatively small but vocal groups may help to define the discussion on public health issues, such as COVID-19 vaccines and treatments.³⁷

Nurses play an important role in engaging with both patients and the public to provide accurate health information. In fact, nurses have a professional, ethical responsibility to only provide information to the public that meets professional standards. Unfortunately, some nurses use social media and other public forums to disseminate misinformation about COVID-19, vaccines, treatments, and masking. The NCSBN has stated that “nurses are professionally accountable for the information they provide to the public.”³⁸ Holding a nursing license is a privilege, and licensees have a responsibility to uphold the standards of the profession and the principles of the ANA’s *Code of Ethics for Nurses with Interpretive Statements*.^{13,38} Nurses who spread misinformation are subject to discipline by their SBONs, which can place their careers and livelihood in jeopardy.³⁸

TOWARD SAFE(R) PRACTICE

The COVID-19 pandemic has held a magnifying glass to the health care system, revealing both its strengths and weaknesses. It has also exposed a number of liability concerns. Fortunately, when nurses are aware of their potential liability exposures, they can identify steps they can take to protect themselves as they continue to care for their patients. ▼

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This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2 contact hours. LPD is also an approved provider of continuing nursing education by the District of Columbia, Georgia, West Virginia, New Mexico, South Carolina, and Florida, CE Broker #50-1223. Your certificate is valid in all states.

PAYMENT

The registration fee for this test is \$21.95.